largely upon early operation. No disease causes such rapid sinking of the vital powers of the patient, and in none are the results of simple laparotomy so dangerous to the life of the individual. The prognosis is always better in those cases which have a stormy invasion. In the slow insidious invasions where the symptoms have existed some time, the integrity of the gut has been compromised before surgical aid is apt to reach the patient. The author tabulates his own cases, both operative and those in which the expectant plan has been followed. In those cases where the strength of the patient has been much exhausted, he advises postponement of the major operation for the radical cure of strangulation (laparotomy) and the substitution of the minor operation of making an artificial anus. The more dangerous procedure is advised after the strength of the patient has improved. Of 10 cases of acute ileus, the radical operation was performed by the author in 6. In only one case did definite cure result. In two cases the laparotomy was successful, but the patients died subsequently of pneumonia. In two additional cases he formed an artificial anus for the exit of fæces as a palliative measure, the patients being in bad condition for the operation of laparotomy; both of these cases were fatal.

The author also calls attention to the great mortality after operation in those cases of stricture of the gut due to carcinomatous growth. In these cases, symptoms, acute in the onset, may appear in subjects who never suffered from anything more marked than inordinate constipation. Cases of this character should be always examined under narcosis. Early diagnosis is also an important factor in the disease.—*Archiv. f. Klin. Chir.* bd. 36. heft 3.

HENRY KOPLIK (New York).

VII. On a Method of Operating so as to Lessen the Dangers of Exsection of Intestine. By E. HAHN (Germany). In cases of strangulated hernia with gangrenous intestine, resection of the intestine and suture of the divided ends was given up by the author after its first trial, owing to the bad results which followed it, but was adopted again when an examination of statistics seemed to show that better results followed after it than after the formation of artificial anus

whether with after treatment by the intestinal spur or secondary resection and suture.

The new method of operating is as follows: The peritoneal opening after the relief of a strangulated inguinal or femoral hernia is enlarged, and the intestine drawn down, ligatured above and below the gangrenous part and resected. The cut ends are thoroughly disinfected and stuffed up to the ligature with iodoform gauze, which is kept in place by a stitch. The ends of this stitch are left long so that when grasped by forceps passed through the mesial abdominal wound (to be afterwards made), they may serve to pull the ends of the intestine through. Next an incision, 6–8 cm. long, is to be made in the linea alba, extending from just below the umbilicus to the level of a line joining the two anterior superior spines. The centre of this incision will be nearly opposite the point where the mesentery crosses from left to right. The surgeon, after carefully protecting the divided intestinal ends from further contamination by inserting gauze into the original wound, now passes a pair of forceps from the mesial to the groin wound and draws them through by the threads left for the purpose. Afterwards he packs the groin wound with gauze and proceeds to inspect, trim and suture with fine silk the ends of intestine at the mesial wound. The mucous membrane is treated with continuous sutures, the peritoneum with Lembert's suture. After the sutured intestine has been again bathed with lotion (2 to 3 per cent carbolic preferred) it is returned into the abdominal cavity, but to prevent risk of escape of fæcal matter and to keep the sutured part in position strips of iodoform gauze are packed round on each side as far as the mesentery. The ends of the strips are left to project at the wound. The sutured part of the intestine is thus kept at the level of the parietal peritoneum, opposite the wound, and may be inspected at will by removing an extra piece of gauze which is laid over it. To keep the gauze in place and to prevent prolapse of intestine from a cough, two or three superficial stitches are inserted and knotted over the gauze. In very weak patients fluid food may be given next day.

As a modification of this method an artificial anus for crural hernia may be made in the middle line.

The advantages claimed for the above method consist:

1. In possibility of exact control of affected intestine and mesentery. This is especially necessary in some cases where thrombosis of mesenteric vessels has occurred.

2. In the facility of resection and of suture of the intestine.

3. In greater certainty of avoiding septic infection from the wound to the peritoneum.

4. In the protection of the sutured intestine, during healing, by the iodoform gauze.

5. In the safe conduction outward of fæcal extravasation should the suture fail.

When in a crural hernia the artificial anus is made in the middle line, kinking and disturbance of the circulation is avoided, while the after treatment of the artificial anus is easy.

No opening in the middle line is required for the secondary suture of an artificial anus in the groin.

Up to the time of writing the author had had two cases of primary and one of secondary intestinal resection and suture, all of them successful.

[The author does not say how long he leaves the packing round the sutured intestine, nor how he closes the abdominal wall after the packing is removed.]—*Berliner Klin. Wochenschrift*, June 25, 1888.

CHARLES W. CATHCART (Edinburgh).

VIII. Case of Perityphlitic Abscess, Implication of Right Hip Joint. By HENRY C. RAWDON (Liverpool). A boy, æt. $6^1/_2$ years, was suffering with disease of the right hip joint, with which was associated a large abscess. About six weeks before admission he was seized with a series of convulsive fits,which extended over a period of three weeks, on recovering from which the boy was found to be unable to walk, and complained of pain about his hips and knees. Shortly after coming under author's care, the head of the femur was excised, giving vent to a large collection of purulent matter occupying the upper and outer part of the thigh. The excised head showed little pathological change; the capsular and round ligaments had given way. The boy was much relieved, and progressed well for two months, al-